DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Corrected 01/19/05

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2004-015

2. STATE: ARKANSAS

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 3, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 Code of Federal Regulations, Part 440.10

7. FEDERAL BUDGET IMPACT:
a. FFY 2005 $ 948,692.00
b. FFY 2006 $1,143,002.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Please See Attached Listing

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Please See Attached Listing

10. SUBJECT OF AMENDMENT:
The Arkansas Title XIX State Plan has been amended to remove the $150,000.00 limit on reimbursement for organ transplants.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mike R. Jeffus

14. TITLE:
Director, Division of Medical Services

15. DATE SUBMITTED:
December 3, 2004

16. RETURN TO:
Division of Medical Services
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attention: Carolyn Patrick

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 8 Dec 2004

18. DATE APPROVED: 2-15-05

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: DEC - 3 2004

20. SIGNATURE OF REGIONAL OFFICIAL: Bill Brodnick

21. TYPED NAME: William Lasowski

22. TITLE: Acting Deputy Director

23. REMARKS:

FORM HCFA-179 (07-92)

ATTACHED LISTING FOR ARKANSAS STATE PLAN TRANSMITTAL #2004-015

8. Number of the Plan Section or Attachment	9. Number of the Superseded Plan Section or Attachment
Attachment 3.1-A, Page 1a	Attachment 3.1-A, Page 1a Approved 10-15-01, TN 01-18
Attachment 3.1-B, Page 2a	Attachment 3.1-B, Page 2a Approved 10-15-01, TN 01-18
Attachment 3.1-E, Page 1	Attachment 3.1-E, Page 1 Approved 10-25-94, TN 94-18
Attachment 3.1-E, Page 2	Attachment 3.1-E, Page 2 Approved 08-20-92, TN 92-31
Attachment 4.19-A, Page 1	Attachment 4.19-A, Page 1 Approved 11-22-99, TN 99-20
Attachment 4.19-A, Page 3	Attachment 4.19-A, Page 3 Approved 10-25-94, TN 94-18
Attachment 4.19-A, Page 3a	Attachment 4.19-A, Page 3a Approved 03-01-99, TN 98-19
Attachment 4.19-A, Page 3b	None, New Page
Attachment 4.19-A, Page 7	Attachment 4.19-A, Page 7 Approved 10-25-94, TN 94-18
Attachment 4.19-A, Page 23	Attachment 4.19-A, Page 23 Approved 07-17-01, TN 01-08
Attachment 4.19-B, Page 2a(1)	Attachment 4.19-B, Page 2a(1) Approved 11-02-04, TN 04-05(A)

STATE ARKANSAS
DATE REC'D DEC - 8 2004
DATE APPV'D FEB 15 2005
DATE EFF
HCFA 179

A

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: December 3, 2004

CATEGORICALLY NEEDY

1. Inpatient Hospital Services

All inpatient admissions to an acute care/general hospital or rehabilitative hospital will be allowed up to four (4) days of service per admission when determined inpatient care is medically necessary. On the fifth day of hospitalization, if the physician determines the patient should not be discharged on the fifth day of hospitalization, the hospital may contact the Quality Improvement Organization (Arkansas Foundation for Medical Care, Inc.) and request an extension of inpatient days. The Quality Improvement Organization (QIO) will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. Medically necessary inpatient days are available to individuals under age 1 without regard to the four day limit and extension procedures required under the plan. Additionally, effective for dates of service on or after November 1, 2001, a benefit limit of 24 days per State Fiscal Year (July 1 through June 30) is imposed for recipients age 21 and older. No extensions will be authorized. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.

Inpatient hospital services required for pancreas/kidney transplants, liver/bowel transplants and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages 2, 4 and 6.

1. Inpatient Hospital Services

All inpatient admissions to an acute care/general hospital or rehabilitative hospital will be allowed up to four (4) days of service per admission when determined inpatient care is medically necessary. On the fifth day of hospitalization, if the physician determines the patient should not be discharged on the fifth day of hospitalization, the hospital may contact the **Quality Improvement** Organization (Arkansas Foundation for Medical Care, Inc.) and request an extension of inpatient days. The **Quality Improvement** Organization (QIO) will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. Medically necessary inpatient days are available to individuals under age 1 without regard to the four day limit and extension procedures required under the plan. Additionally, effective for dates of service on or after November 1, 2001, a benefit limit of 24 days per State Fiscal Year (July 1 through June 30) is imposed for recipients age 21 and older. No extensions will be authorized. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program.

Inpatient hospital services required for pancreas/kidney transplants, **liver/bowel transplants** and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages 2, 4, and 6.

Revised: **December 3, 2004**

State/Territory: ARKANSAS

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The Arkansas Medicaid Program covers Corneal Transplants, Renal Transplants, Heart Transplants, Liver Transplants, Non-Experimental Bone Marrow Transplants and Lung Transplants for eligible Medicaid recipients of all ages. Pancreas/Kidney Transplants, **Liver/Bowel Transplants** and Skin Transplants for Burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

Corneal Transplants

Corneal transplants require prior authorization. Medicaid will pay for hospitalization, physician services and follow-up care when associated with corneal transplants. Covered benefits include the acquisition and preservation of the organ from a cadaver donor. Corneal transplants are subject to the same inpatient hospital, outpatient and physician benefit limits as all other covered inpatient, outpatient and physician services.

Renal Transplants

Renal transplants require prior authorization. Benefits are provided for the following services related to renal transplantation:

- Hospitalization and physician services for the removal of the organ from the living donor.
- Harvesting of the organ for renal transplant from a cadaver donor is reimbursed through the hospital cost settlement process.
- Transportation and preservation of the organ from a living or cadaver donor.
- Hospitalization and physician services for transplanting kidney into the receiver.
- Follow-up care.

Renal transplants are subject to the same inpatient hospital, outpatient and physician benefit limits as all other inpatient, outpatient and physician services for both donor and receiver.

Heart Transplants

Heart transplants require prior authorization. Benefits are provided for the following services related to heart transplantation:

- Procurement (harvesting) of the organ from a cadaver donor. Cost will be included in the hospital charges.
- Hospitalization and physician services for transplanting the heart into the receiver.
- Post-operative care until discharged from the hospital.

Liver **and Liver/Bowel Transplants**

Liver **and liver/bowel** transplants require prior authorization. **Liver/Bowel transplants are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program.** Benefits are provided for the following services related to liver **and liver/bowel** transplantation:

- Hospitalization and physician services for the removal of the organ from a living donor.
- Procurement (harvesting) of the organ from a cadaver donor. Cost will be included in the hospital charges.
- Hospitalization and physician services for transplanting the liver **and liver/bowel** into the receiver.
- Post-operative care until discharged from the hospital.

Heart, Liver **and Liver/Bowel** Transplants are not subject to the established benefit limits for inpatient hospital services described elsewhere in the State Plan. Services excluded from the inpatient benefit limit are those services provided from the date of the transplant procedure to the date of discharge. The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: December 3, 2004

1. Inpatient Hospital Services

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

In accordance with Section 1902(s) of the Social Security Act, we do not impose dollar limits on any inpatient hospital services for children under age one (or children that are hospitalized on their first birthday). This includes the $675.00 upper payment limit, the TEFRA rate of increase limit, the customary charge upper limit or the $150,000 **bone marrow** transplant limit. This applies to all inpatient hospitals.

Effective for claims with dates of service on or after July 1, 1991, all acute care hospitals with the exception of Pediatric Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals and Out-of-State Hospitals, will be reimbursed based on reasonable costs with interim per diem rates and year-end cost settlements, with an upper limit of $584.00 per day.

Effective for claims with dates of service on or after April 1, 1996, all acute care hospitals with the exception of Pediatric Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals and Out-Of-state Hospitals will be reimbursed based on reasonable cost with interim per diem rates and year-end cost settlements, with an upper limit of $675.00 per day. The upper limit was established taking the 90th percentile of the cost based per diems using their 1994 year end cost reports. This does not include the hospitals listed above as exceptions.

Effective for claims with dates of service on or after January 1, 1997, the upper limit of $675.00 per day will be applied to Arkansas State Operated Teaching Hospitals. The upper payment limit will apply to allowable costs; except GME payments will not be subject to the upper limit. Effective for cost reporting periods ending on or after June 30, 2000, the upper limit of $675.00 per day will no longer be applied to Arkansas State Operated Teaching Hospitals.

Arkansas Medicaid will use the lesser of cost or charges to establish cost settlements. If the lesser of cost or charges exceed the upper limit payment times total hospital Medicaid days, then the upper limit payment times the total hospital Medicaid days will be used to calculate the cost settlement. Effective for dates of service on or after July 1, 1991 thru March 31, 1996, the upper limit payment

1. Inpatient Hospital Services (Continued)

Direct medical education costs, including graduate medical education costs, are reimbursed based on Medicare reasonable cost rules in effect prior to the effective date of the September 29, 1989 rule.

TRANSPLANT SERVICES

A. In-State Acute Care/General Hospitals, All Bordering City Hospitals and All Out-of-State Hospitals

1. **Corneal, Renal and Pancreas/Kidney Transplants**
Inpatient hospital services required for corneal, renal and pancreas/kidney transplants are reimbursed in the same manner as other inpatient hospital services.

2. **Bone Marrow Transplants**
Interim reimbursement for bone marrow transplants will be 80% of billed charges, subject to subsequent review to determine thatonly covered charges are reimbursed. Reimbursement will not exceed $150,000. Reimbursement includes all medical services relating to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the $150,000 maximum, reimbursement for each provider type will be decreased by an equal percentage resulting in an amount which does not exceed the maximum dollar limit.

3. **Other Covered Transplants**
Hospital services (does not include organ acquisition) relating to other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow) are reimbursed at 45% of submitted charges. Reimbursement includes all allowable medical services relating to the covered transplant from the date of the transplant procedure to the date of discharge. Transplant hospitalization days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

Inpatient hospital days prior to the transplant date will be reimbursed in accordance with the applicable State Plan methodology for the hospital type in which the transplant is performed.

Readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant service at 45% of submitted charges. All excess length of stay approval requirements also apply.

1. Inpatient Hospital Services (Continued)

A. **In-State Acute Care/General Hospitals, All Bordering City Hospitals and All Out-of-State Hospitals (Continued)**

3. **Other Covered Transplants (Continued)**

Reimbursement for the actual organ to be transplanted (organ acquisition) will be at (a) 100% of the submitted organ invoice amount from an outside organ provider organization or (b) reasonable cost with interim reimbursement and year-end cost settlement. The hospital has the choice of using either method. If (a) is used, the provider will submit a copy of the invoice for the organ acquired and Medicaid will reimburse 100% of the invoice amount and no additional amounts will be reimbursed to the hospital. If (b) is used, an interim amount will be reimbursed to the hospital and a year-end cost settlement will be calculated. The interim amount reimbursed and the year-end cost settlement will be calculated in a manner consistent with the method used by the Medicare Program for organ acquisition costs.

B. **In-State Pediatric Hospitals and Arkansas State Operated Teaching Hospitals**

1. **Corneal, Renal and Pancreas/Kidney Transplants**

Inpatient hospital services required for corneal, renal and pancreas/kidney transplants are reimbursed in the same manner as other inpatient hospital services.

2. **Bone Marrow Transplants**

Interim reimbursement for bone marrow transplants will be 80% of billed charges, subject to subsequent review to determine thatonly covered charges are reimbursed. Reimbursement will not exceed $150,000. Reimbursement includes all medical services relating to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the $150,000 maximum, reimbursement for each provider type will be decreased by an equal percentage resulting in an amount which does not exceed the maximum dollar limit.

3. **Hospital services provided by In-State Pediatric Hospitals and Arkansas State Operated Teaching Hospitals relating to other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement. Reimbursement includes all allowable medical services relating to the covered transplant from the date of the transplant procedure to the date of discharge. Transplant hospitalization days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.**

Inpatient hospital days prior to the transplant date will be reimbursed in accordance with the applicable State Plan methodology for the hospital type in which the transplant is performed.

Readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant service. All excess length of stay approval requirements also apply.

C. **Recipient Financial Services**

The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: December 3, 2004

1. Inpatient Hospital Services (Continued)

Effective for claims with dates of service on or after July 1, 1994, hospitals in bordering cities will be reimbursed based on reasonable costs with interim per diem rates and year-end cost settlements, with an upper limit of $584.00 per day.

Effective for claims with dates of service on or after April 1, 1996, allhospitals in bordering cities will be reimbursed based on reasonable cost with interim per diem rates and year-end cost settlements, with an upper limit of $675.00 per day. The upper limit was established taking the 90th percentile of the cost based per diems using their 1994 year end cost reports as explained on Attachment 4.19-A, Page 1.

Effective for claims with dates of service on or after July 1, 1994 thru March 31, 1996, the upper limit payment of $584 will be applied. Effective for claims with dates of service on or after April 1, 1996, the upper limit payment of $675 will be applied.

Effective for claims with dates of service on or after March 1, 1999, hospitals located in Springfield, Missouri will qualify to be designated as a bordering city hospital and will be reimbursed based on reasonable cost with an interim per diem rate and year-end cost settlement. The upper limit of $675 will be applicable.

The following cities which are located within a fifty (50) mile trade area are considered bordering cities: Poplar Bluff, Missouri; Springfield, Missouri; Greenville, Mississippi; Poteau, Oklahoma; Memphis, Tennessee and Texarkana, Texas.

All other reimbursement information contained in Attachment 4.19-A, Pages 1 through 3, pertains to bordering city hospitals.

The TEFRA base year will be the first full cost reporting period beginning on or after July 1, 1991.

1. Inpatient Hospital Services (Continued)

Pediatric Hospitals (Continued)

Refer to Attachment 4.19-A, Page **3 and 3a,** for the reimbursement methodology for **transplant services.**

Arkansas' method of reimbursing malpractice insurance for pediatric hospitals will be a simple calculation made outside the cost report and the result added back on to the Medicaid settlement page of the report. The calculation would apply a Medicaid utilization factor based on cost to the portion of total malpractice expense (91.5%) which is reimbursed for Medicare on worksheet D-8 of the cost report. The remaining 8.5% remains on worksheet A of the cost report and flows through to be reimbursed like any other administrative cost. The final result would be to reimburse malpractice for Medicaid as though all malpractice expense remained on worksheet A and simply flowed through the cost report.

Direct medical education costs, including graduate medical education costs, are reimbursed based on Medicare reasonable cost rules in effect prior to the effective date of the September 29, 1989 rule.

4. Reimbursement for Inpatient Hospital Services for Children Under Age One (or Children that are Hospitalized on Their First Birthday)

Medically necessary inpatient hospital services furnished to children under age one (or children that are hospitalized on their first birthday) will be exempt from any dollar limits on any inpatient hospital service.

Inpatient hospital services **(excluding other covered transplant services for In-State Acute Care/General Hospitals, all Bordering City Hospitals and all Out-of-State Hospitals)** for these individuals will be cost settled separately from all other Medicaid recipients and no dollar limits will be applied.

Arkansas Medicaid will not consider these costs in the Medicare TEFRA rate of increase limit computation.

5. Physicians' Services (continued)

Reimbursement for physicians' services for bone marrow transplants is included in the $150,000 maximum as described in Attachment 4.19-A. Procedures will be manually priced based on professional medical review. The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

Reimbursement for physician's services for corneal, renal and pancreas/kidney transplants will be reimbursed in the same manner as other non-transplant related physician services.

Other Covered Transplant Services

Physician services relating to other covered transplant surgery procedures (does not include corneal, renal, pancreas/kidney and bone marrow) will be reimbursed at the lesser of negotiated rates or 80% of billed charges. Physician reimbursement at the lesser of negotiated rates or 80% of billed charges is applicable for all allowable physician services relating to the other covered transplant from the date of the transplant procedure to the date of discharge. Physician reimbursement at the lesser of negotiated rates or 80% of billed charges will be reimbursed for the same dates of service as are allowed for hospital services for other covered transplants (See Section 4.19-A). For hospitals, transplant related days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

Physician services provided prior to the date of transplant will be reimbursed in the same manner as other non-transplant related physician services.

Allowable services provided during dates of readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant services at the lesser of negotiated rates or 80% of billed charges. All excess length of stay approval requirements also apply.

Payment is made directly to the physician or, upon request of the physician, payment is made under the Deferred Compensation Plan.

Participation in the Deferred Compensation Plan by a physician is entirely voluntary. The individual physician's authorization and consent is on file. The physician submits his claim in the usual manner, and after verification, the appropriate amount due the physician is deposited in an account administered by First Variable Life Insurance Company or The Variable Annuity Life Insurance Company up to the maximum amounts allowed by the Revenue Act of 1978. Each account in the investment funds is individualized as to each physician participating. Arkansas Division of Medical Services has no responsibility for management or investment of these funds. Federal matching is not claimed for any part of the administration of the Plan. This is a service designed to increase the number of participating physicians in the Medical Assistance Program.

Desensitization injections - Refer to Attachment 4.19-B, 4.b. (15).